Exhibit B: HPC Questions for Written Testimony

1. Chapter 224 of the Acts of 2012 (Chapter 224) sets a health care cost growth benchmark for the Commonwealth based on the long-term growth in the state's economy. The benchmark for growth in CY2013 and CY2014 is 3.6%.
    a. What trends has your organization experienced in revenue, utilization, and operating expenses in CY2014 and year-to-date CY2015? Please comment on the factors driving these trends.

    Our facility has seen a continuing decrease in reimbursement for Pain Management procedures. We have seen an increase in utilization due to the addition of a number of new surgeons and the increase in the number of cases other surgeons have added. Surgeons can do four or five cases at an HOPD versus ten or eleven cases at the center due to the turnover time. The center works with two group purchasing organizations and our materials manager works with supplier representatives on a consignment plan for some of the supplies, all in an effort to keep supply costs down. The center has increased the staff health insurance deductible to minimize the centers contribution. All of these efforts to control costs are accomplished with ASC being paid only 58% of what the HOPD's are paid, and still saving the patient, payers and the State.

    b. What actions has your organization undertaken since January 1, 2014 to ensure the Commonwealth will meet the benchmark, and what have been the results of these actions?

    The center has talked with payors in an effort to move more procedures to the ASC from the HOPD. This would help in controlling health care spending due to ASC being paid only 58% of what the HOPD's are paid but allowing patients to still receive the high quality health care.

    c. Please describe specific actions your organization plans to undertake between now and October 1, 2016 to ensure the Commonwealth will meet the benchmark, including e.g., increased adoption to alternative payment methods (including specifically bundled/episodic payments), participation in CMS Medicare Shared Savings, Pioneer or Next Gen programs?

    Our center has embraced price transparency by providing patients with high deductibles or no insurance, the opportunity to bundle surgeon/facility/anesthesia into one price.

    d. What systematic or policy changes would encourage or enable your organization to operate more efficiently without reducing quality?

    - The facility could operate more efficiently if less time was spent providing duplicate data to multiple organizations under one department.
    - ASC's should not continue to be lumped in with hospitals and required to provide data on patient types we do not see in a same day surgery setting.
    - Produce legislation that prohibits exclusive referral arrangements. All physicians should be allowed to access the lower cost service of an ASC that maintains equal or greater quality service to that of the HOPD.

- Remove the Determination of Need guidelines enabling existing ASC growth.

2. What are the barriers to your organization's increased adoption of alternative payment methods and how should such barriers be addressed?
    - Barriers preventing adoption of alternative payment methods is the continued inequity of fee schedules between ASC's and HOPD's.
    - HOPD's should be paid at the same rate as ASC's.
    - Payors should not be afraid to anger the hospitals by allowing more procedures to be done in the ASC's.

3. In its prior Cost Trends Reports and Cost Trends Hearings, the Commission has identified four key opportunities for more efficient and effective care delivery: 1) spending on post-acute care; 2) reducing avoidable 30-day readmissions; 3) reducing avoidable emergency department (ED) use; and 4) providing focused care for high-risk/high-cost patients.
    a. Please describe your organization's efforts during the past 12 months to address each of these four areas, attaching any analyses your organization has conducted on such efforts.
        1. ASC's day surgery does not require post-acute care
        2. N/A surgery center
        3. Only doing cases appropriate for day surgery reduces emergency department use
        4. N/A not done at ASC

    b. Please describe your organization's specific plans over the next 12 months to address each of these four areas.
        The ASC will continue to pre-op screen patients and only do those appropriate for day surgery

4. As documented by the Office of the Attorney General in 2010, 2011, and 2013; by the Division of Health Care Finance and Policy in 2011; by the Special Commission on Provider Price Reform in 2011; by the Center for Health Information and Analysis in 2012, 2013, and 2015; and by the Health Policy Commission in 2014, prices paid to different Massachusetts providers for the same services vary significantly across different provider types, and such variation is not necessarily tied to quality or other indicia of value. Reports by the Office of the Attorney General have also identified significant variation in global budgets.
    a. In your view, what are acceptable and unacceptable reasons for prices for the same services, or global budgets, to vary across providers?
        There is no acceptable reason for prices to vary across providers. The exact same procedure done in a more expensive and less efficient hospital outpatient facility can be accomplished at a free standing ambulatory surgery center for a fraction of the cost.

b. Please describe your view of the impact of Massachusetts' price variation on the overall cost of care, as well as on the financial health and sustainability of community and lower-cost providers.
Price variation, as is, could lead to Massachusetts' never meeting the benchmark. The continuation of the hospitals pressure on physicians to refer only to affiliates prevents ASC's from continuing to grow. The discrepancy in fees paid to ASC's by different payors could cause these excellent facilities, that provide service at a much lower cost to no longer be viable. If ASC's are no longer viable and available to the community that would leave the HOPD's to become a monopoly, causing the state to pay only the higher prices.

5. The Commission has identified that spending for patients with comorbid behavioral health and chronic medical conditions is 2 to 2.5 times as high as spending for patients with a chronic medical condition but no behavioral health condition. As reported in the July 2014 Cost Trends Report Supplement, higher spending for patients with behavioral health conditions is concentrated in emergency departments and inpatient care.
   a. Please describe ways that your organization has collaborated with other providers over the past 12 months 1) to integrate physical and behavioral health care services and provide care across a continuum to these patients and 2) to avoid unnecessary utilization of emergency room departments and inpatient care.
   N/A this does not pertain to free standing ambulatory surgery centers

   b. Please describe your specific plans for the next 12 months to improve integration of physical and behavioral health care services to provide care across a continuum to these patients and to avoid unnecessary utilization of emergency room departments and inpatient care.
   N/A as above

6. The Commission has identified the need for care delivery reforms that efficiently deliver coordinated, patient-centered, high-quality care, including in models such as the Patient Centered Medical Home (PCMH) and Accountable Care Organizations (ACOs). What specific capabilities has your organization developed or does your organization plan to develop to successfully implement these models?
   N/A as above as the ASC's are not involved with home care or ACO's